

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-022762

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 677

STATE FILE NUMBER

FILED JUN 11 1963

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>MEHLVILLE</u>		c. CITY OR TOWN <u>FLORISSANT</u>	
Length of stay in 1b <u>16 mos</u>		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
c. FULL NAME OF (If not in hospital, give location) <u>FULLER NURSING HOME</u>		d. STREET ADDRESS (If outside, give location) <u>2340 CARDINAL DR.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>M.</u> Last <u>SCHWEPPE</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>23</u> Year <u>1963</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-1-1961</u>
9. AGE (last birthday) <u>1</u>		10. AGE (last birthday) IF UNDER 1 YEAR Months <u>6</u> Days <u>22</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NIL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NIL</u>	
11. BIRTHPLACE (City and state or country) <u>LANCASTER, CALIF</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>NORBERT SCHWEPPE</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH SCHNEIDER</u>	
14. NAME OF HUSBAND OR WIFE <u>NIL</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <u>NIL</u>	
16. INFORMATION <u>NORBERT SCHWEPPE FLORISSANT MO</u>		17. ADDRESS <u>2340 CARDINAL DR</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL ISCHEMIA</u> DUE TO (b) <u>CONGENITAL HYDROCEPHALUS</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>18 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY <u></u> STATE <u></u>	
21. I attended the deceased from <u>3:25 P</u> to <u></u> and last saw her/him alive on <u></u> Death occurred at <u></u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Milton Karden, MD.</u> (Degree or title)		22b. ADDRESS <u>9293 Highway 66 ST. LOUIS 26, MO.</u>	
22c. DATE SIGNED <u>5-24-63</u>		22d. LOCATION (City, town, or county) (State) <u>MEHLVILLE MO</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>5-24-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW ST JOHNS Cem.</u>	
23d. LOCATION (City, town, or county) <u>MEHLVILLE MO</u>		23e. DATE RECD. BY LOCAL REG. <u>5-24-63</u>	
24. FUNERAL DIRECTOR <u>FEY FUNERAL HOME</u>		25. REGISTRAR'S SIGNATURE <u>John B. Murphy, M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

*No EMBALMING*  
*PER. J. L. L. Aug 8.*

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.